The Nova Scotia Medical Bulletin

JULY 1929

Leading Features This Issue:

MEDICAL NOTES ON BURGOYNE'S CAMPAIGN BY MAJOR R. M. GORSSLINE, R.C.A.M.C.

C. M. A. MEETING

BRANCH SOCIETIES

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Medical Organization*

THIS general term is employed for its brevity and in default of a better term. What we wish to understand and consider very briefly is a definite systematic effort on the part of the medical men in Nova Scotia to co-operate efficiently in giving a better service in the humane work of the care and cure of those sick, the improvement of health and the prevention of disease.

In the first place, let us for a moment ask ourselves if, in our Society meetings, we are giving sufficient attention to those vital subjects which are not strictly *scientific* as we frequently use the term. The fact of asking the question suggests a part of the answer. These are matters upon which we all agree and which we readily endorse, so why waste the time of a medical society meeting in their consideration. But we go farther and carry this same spirit of indifference to our consideration of matters affecting our own profession. Some one presents a subject to obtain an expression of opinion, when we have comments thus:—

"I move this matter lie on the table:—I move this matter be referred to the Annual Meeting or some other body, etc."

This happens at many meetings of local Societies and our Executives, which are the bodies which should take the time and give the thought necessary to form an intelligent opinion upon all matters relating to our profession or the welfare of the community. Only in this way can the profession make such progress as will justify our claim to be regarded as leaders in Health Work.

But some one suggests that at the rate things in this line are moving to-day it is better the Medical Profession should be the Brake on the so-called Progress Chariot. Even at that let us be fair and not claim anything else.

This suggests one of our problems to which we should devote time and thought—how to steer a wise course between the extremes of reactionary (ultra Conservative) and radical (ultra Progressive) opinions, at the same time being wisely Liberal. How to be progressive and not be dreamers and faddists; how to progress wisely and carefully; how to visualize every avenue of progress. We must recognize the existence of this problem and we submit that at gatherings of the Society much time could profitably be devoted to the consideration of topics suggested in these opening paragraphs.

It goes without necessity of argument that we have already entered upon another phase of medical progress. We published recently in the BULLETIN an article entitled "The Romance of Surgery"

*Presented at a meeting of the Eastern Counties Medical Society in 1928.

and the 25 years from 1894 or 95 may well represent this period of astonishing progress. Already there are many signs that we have now entered upon a period of progress which the historian will describe as the "Romance of Medicine", when the Internist shall come into his own. True, it is, that this path will be longer, more laborious and perhaps, withal, less spectacular than the other. If we could only visualize this progress in its immensity, in its wonderful day-breaking from the qualms of fear caused by the dark clouds of despair and the black night of failure, into the glorious day of success in the prevention of disease, an entire profession united in preventing suffering and incapacity, when old age is the sole enemy left in the field—if we could only rise to this vision, the Romance of Medicine will be a Prophecy fulfilled before we can realize it.

In the prevention of disease we have our chief means of relieving distress. One of the difficulties is in changing our established course, we are inclined to be "Continuing" practitioners. We glory in the history of our success in curing disease. "Ours is an avocation than which none is more honored. If there is any joy that men should prize it is the joy to relieve distress. Yet note the exalted position that Medicine is destined to occupy. If there is a greater joy it is that of preventing distress." We should be prepared to accept this almost boundless scope of our operations.

Incidentally we should remind ourselves that the pathology of curative medicine is many times exceeded by the pathology of preventive medicine. While ostensibly we are lessening the field of our activities in our endeavors to prevent disease from which we have, and still are, earning an honest, but more or less insufficient livelihood, we are actually greatly increasing the field of operation. The maintenance of health by inspection of school children, correction of defects, periodic health examinations, immunization in disease, earlier recognition of cancer, tuberculosis, etc., merely indicates a few items in this larger programme. We still find hostility to health clinics and lay health organizations. Yet they are building for your future enlarged service which cannot be given without remuneration. When we sift this matter carefully have any of these things seriously affected us financially even when their conduct has been open to legitimate criticism.

To illustrate:—Some can recall very large fees obtained when diphtheria struck a family; did we suffer a serious loss when antitoxin came to be used; will we suffer when immunization becomes general whenever the disease appears? How about Typhoid? There is not enough of it to give clinical lectures in some medical colleges today, yet our incomes still exist. Some years ago we greatly concerned ourselves with the refusal of some Life Assurance Companies to pay five dollars for each examination. When they committed themselves to insurance without medical examination we feared we had killed the goose that laid the golden egg. Now these Companies are the greatest

propagandists of periodic health examinations a much more profitable service to the physician, and perhaps it will be undertaken more seriously. The Canadian Medical Association, in a pamphlet issued by the Department of Health, Ottawa, says:—

"The greatest possibilities of periodic health examinations are no idle dream. When the physician advises concerning the whole life of the individual, he assumes an increasingly intimate relationship with the family under his care. To the family physician this should make a special appeal."

The latter is but one instance where present health propaganda will very definitely increase the work of the general practitioner, unless from some foolish idea of medical ethics the doctor queers this and other similar proposals. Perhaps the best rule to follow is, "What is in the best interests of the men, women and children?" If we are not able to make their best interests also ours, perhaps the blame had better be attached to us.

Now, recognizing this larger field, what has "Medical Organization" to do with it? Perhaps two phases of the matter may be dealt with:—viz:

1. Organization of ourselves for ourselves, and,

2. Organization for purposes of co-operation.

In the first place medical organization is necessary to us for our own scientific improvement and the keystone of this organization is the local unit, the city or county Society. When 100% of the profession are actively identified with the local society, which is a branch of a district or provincial society, and these men realize their responsibilities and privileges, there is practically nothing in the highest interests of our noble art that may not be achieved. Unitedly the family doctors may easily direct the entire thought of the community when they speak with authority. But to do so they must get together. If not there is no co-operation, each ploughs his own little furrow and it is neither broad, deep or adapted to the other furrows. But no man liveth to himself and there is no medical man in the world but might learn something from his confreres, and no man in general practice but needs all he can learn. Post graduate courses are impossible for many of our medical men for obvious reasons, but, in the rubbing of shoulders, the exchange of experiences, the applications of the opinions expressed in a medical address, the finding and absorbing the ideas of a fellow practitioner, this occurring once, twice, four or more times each year, there is a practical post graduate course furnished equal, and in some ways superior, to that furnished at great expense by the largest and best of our hospitals or universities.

Upon this point but one thing more need be said. To-day it is regarded by the public if any doctor to says he won't go to a medical society to listen to his confreres blow their own horns it is an indication

of weakness. The physician's clientele to-day has little respect for his knowledge and ability if he does not attend medical society meetings. In particular does this apply to towns and rural districts, but even in cities one hears from time to time a slighting remark that Dr. A. doesn't know enough to attend their meetings. If one does not keep in touch with the local society it is but a short step to the time when he ceases to buy books or read medical journals and modern practice soon becomes to him a *terra incognita*. As medical practitioners, we cannot afford for personal reasons to neglect our local and provincial societies.

But organization for co-operation opens up a large field more in accord with the thoughts suggested in the first part of this paper.

In a broad view of the work of the improvement of health and the prevention of disease there are obviously three agencies to be employed.

1. The Medical Profession.
2. The Department of Public Health.
3. The General Public.

We claim priority throughout for the medical men, individually and collectively in and through the hospitals, universities and societies. This is the agency to furnish the ideas and personnel through which government authorities will discharge their obligations to people in the Department of Public Health. Yet with all of this there is, in the third place, the general public which demands the best service these two agencies can render. Furthermore through its multitudinous agencies it stands ready to co-operate with these agencies for its own well being. Perhaps it may not be amiss to intimate that the call from the people is loud and clear for leadership, and grumblings are heard because it is not forthcoming to the extent desired. This has given rise to the establishment of lay organizations to develop activity along almost every line of public welfare, *health* naturally claiming the largest number of such bodies. This voice must be heeded, for, though it is a 'voice crying in the wilderness' it may otherwise hasten prematurely what still appears to us as the bogy of State Medicine.

Perhaps the consideration of one form of health activity may be very briefly considered as illustrative of both failure and success by co-operation in health work. As organization is necessary for the continued education of the doctor so it is for the education of the public in health matters. Here, besides lay organizations, is introduced another important factor in health work. Health is essentially, in the last analysis, an individual matter of the man, woman or child. Health education must therefore be given everywhere, but chiefly to the individual in the home. The doctor cannot do it as is readily apparent. We have therefore developed in the last 25 years a special agency, the Health Nurse, for this purpose. Nearly 25 years ago I

employed the first Health Nurse in Nova Scotia to visit homes in Colchester County where Consumption was present or suspected. Until 1914 this service was more or less intermittently carried on. It fully demonstrated that educational health work can be done satisfactorily chiefly in this way.

As I view the whole situation the medical men in Nova Scotia should use their Local Societies and the Provincial Society to secure co-operation with the Public Health Department, the many lay organizations in existence, in a concerted effort to promote health education and proper living throughout the Province, in order that disease may be prevented, health promoted and distress conditions relieved in Nova Scotia.

S. L. W.

Only Trained Attendants at Nova Scotia Hospital.

The following information concerning the Training School at the Nova Scotia Hospital, Dartmouth, is kindly supplied by the Superintendent, Dr. F. E. Lawlor:

"We now only employ male attendants who are sufficiently educated to take the course of training, the same as our nurses. We have found that we have no trouble in obtaining suitable material, proper inducement being offered. After the man has finished his first year of the course and passed his examinations he receives remuneration for his work at the rate of fifty cents more per day, and after passing the final examination, if he is kept in our employ, receives a salary of $80.00 per month, board, lodging, clothing and certain other requisites. By doing this we have been able to abolish the necessity of obtaining undesirables who are only looking for occupation for a short time.

"I find that the personnel of our male nursing staff is greatly improved and that conditions on our male wards are also much better than they used to be.

"I would like to suggest that this matter be brought to the attention of other hospitals. If they desire to improve the personnel of their male nurses, some demarcation should be drawn between hospital attendants and male nurses and extra inducement offered to young men who will take the course in nursing.

"I fully believe that the effort is worth while trying. Men who realize that they are nursing sick people prove to be far more beneficial than those who simply act as guards or attendants."—(*Bulletin Canadian Mental Hygiene Council.*)

What The Public Say

(The following editorial from the Halifax Chronicle of February 19th, 1925, under the title, "The Medical Profession", is herewith given in full for the information of the Profession in Nova Scotia.)

THE MEDICAL PROFESSION.

IN such an age of progress as this we are inclined to become complacent. We see the almost magical advances of science on every hand. We are surrounded by a mechanical necromancy that would turn green with envy the Merlins of yesterday. Look, we cry, how wonderful are the works of Man. But, because of the character of our education, covering an even wider area, we fail to realize that we are entirely ignorant of the real truth of most matters that do not definitely concern the specialty in which we are particularly interested. And even our little specialty may have broadened so enormously that no one man's brain can hold the whole truth or knowledge of it all.

Take as an example, the science of medicine. It is no longer possible for one man to understand completely the whole of that science. Already it has been broken up into specialties—Medicine, Surgery, Diseases of Women and Midwifery, Eye, Ear, Nose and Throat; Orthopaedics, Urology, Diseases of Children, and so on into an ever-widening array. Indeed, even in these specialties, though a man give his whole time to one of them, he is not able to keep up wholly with the new knowledge. What then, of the general practitioner, who, after graduating from college, ceases to study the rest of his life? In five years the knowledge he acquired at the University has begun to get out of date; in ten years it is more so, in twenty years it is almost obsolete. So that any Doctor who has clung to the University-gained knowledge of his twenties without constantly renewing it, is a "back number" in his forties. Because at the University and the Hospital he gained enough knowledge to enable him to pass the requirements of his Province and deal after a certain manner with disease, he must not let matters stop at that. It must be brought home to him that he owes it to his community not merely to treat its ills according to his lights, but according to lights that are continuously advancing. It is true that there are men with tender consciences and great ambitions in Nova Scotia who do try to forge onward, men like the late Sir James Mackenzie, who, as a general practitioner, made discoveries which revolutionized the knowledge of a certain branch of medicine. But these are rare cases.

In an individualistic society such as ours few men in the professions or otherwise realize that they are, when the last word has been said, servants of the public. This is, and must be particularly true of the

medical profession. The non-recognition of it by the doctors themselves, has led to a system under which people have to deliver up their lives, in spite of the great advances of medical science, to obselete methods of practice and diagnosis. This system has led also to the apathetic attitude of both the profession and the public to the great and urgent matter of the prevention of disease. Doctors are to be found in the City of Halifax so short sighted and so steeped in prejudice that they not only fail to see the necessity of preventive medicine but actively oppose it.

The trouble is that most of us do not realize the necessity for a carefully trained medical profession and an active campaign of preventive medicine. Nor do we, through the very closed nature of the guild of medicine, learn except by surmise of the fatal mistake which some doctors make because of a deplorable ignorance. Furthermore, it has not been impressed sufficiently on the graduating doctor that he should not only be a servant of the public, but a teacher of the public. It is the duty of every practising physician to educate that part of the community in which he happens to live in the means and ways by which the ninety per cent of diseases that is preventable may be prevented. But how many doctors do you hear preaching from the hilltops of Nova Scotia that hygiene should be one of the first laws of life, in order that we may accomplish the ancient ideal of a sound mind in a sound body?

The public must wake up to these facts. They must cease to be complacent over a profession that can whip their appendix out so easily for a fat fee and ask why that profession does not teach them how to avoid appendicitis. They should insist that the physicians throughout this Province not only pass a high standard of graduation into the profession of medicine, but maintain that standard. It is true there is a difficulty there for the maintenance of a high standard to-day rests with the individual doctor and the public have insufficient knowledge by which to gauge such a standard. But why should not the profession as a whole, since it is the servant of the public, prove its stewardship every five or ten years by sitting for an examination? We demand that our politicians place their wares before us anew every four or five years; why not our Doctors, on whose proficiency our very lives depend, on whose ability as teachers of health, the health of the next generation of Nova Scotians hang?

Such a test would ensure that the men practising medicine throughout Nova Scotia had at least kept up to a certain standard, and had not, as so many have done, deteriorated from that standard. In the Army a Captain in the Medical Corps must pass an examination in the subject of Medicine before he becomes a Major. Such an examination need not embody highly technical subjects, but should be a thoroughly searching evidence that the doctors of this land had kept well up to the most modern teaching of the great science to which they have dedicated their lives.

We realize to the full that there are many fine-hearted noble men in the profession of medicine in our midst. We have nothing but praise for them. They have labored and struggled to keep in the forefront of their advancing science and in the main have done so. They fully realize their duties to their profession and to the public. They are mainly to be found on the staffs of our hospitals.

But there is always the less than average doctor to whom we must trust our lives and we are entitled to exact a real proficiency from him.

Rest in Tuberculosis.

General systemic rest is the foundation of the treatment of tuberculosis. Tuberculosis lungs, like other diseased organs, heal best when at rest. Bed rest not only conserves the energy supply of the entire body, but also lessens the activity of the lungs. Postural rest and the chest splint are valuable in that they reduce the work of the lung most affected. It has long been known that spontaneous pneumothorax often has a beneficient effect in tuberculosis, due to the enforced rest of the lung brought about by the pneumatic pressure. Pleural effusion, a common complication of pulmonary tuberculosis, also tends to compress or "splint" the lung, while pleural adhesions often serve to limit the motion of the diseased part. With these natural methods of inducing rest of the affected lung as a cure, surgical methods to secure partial or complete immobilization of the lung have been devised. Surgical procedures imitate the natural methods but are more precise and aim to avoid the disadvantages of spontaneous artificial pneumothorax is proving its great value as an adjunct in the treatment of pulmonary tuberculosis.

Jones rang the bell at the new doctor's house. The doctor's wife answered the ring.

"You wish to see the doctor?" she said. "Couldn't you come to-morrow morning?"

"Why," said Jones, "isn't the doctor in?"

"Oh, yes, he's in," said the young wife wistfully, "but you're his first patient and I'd like you to come as a surprise for him to-morrow. You see, it's his birthday."—*Boston Transcript.*

"Is your mother at home?" asked the dapper salesman at the door of the Wimple home.

"Sure," grinned little Johnny, who answered his knock, "but you ain't got a chance, big boy—pa's in off the road."

Common Extrinsic Anatomical Derangements of the Intestine which Influence Maintenance of Health*

By Sir Henry M. W. Gray, K. B. E., C. B., C. M. G., LL. D., M. B., (Aberd.) F. R. C. S., (Ed.)

Mr. President and Gentlemen:

Very large numbers of people are possessed of one or other or all of the developmental aberrations involving the alimentary canal which I have shown you on the lantern pictures. One can often "spot" them as one walks along the streets. A proportion of these may never suffer in any apparent way. In virtue of their healthy habits and the good tone of the muscles of both their abdoninal wall and intestines, the majority may not show any symptoms until change of habits, illness or stretching of abdominal muscles from pregnancy etc. reduces that tone. Many of these begin to show symptoms within a few years after they leave school or college. A small number may, because of the severity of the derangement, suffer from abdominal symptoms from early childhood onwards.

Variability of symptoms, both abdominal and general, often leads to a diagnosis of hysteria or hypochondriasis or neurasthenis. Such patients are apt to become introspective and to think of little else than their misery. They become a nuisance to everybody. Careful abdominal examination reveals the condition of affairs. Diagnosis is both accurate and easy when physical examination is properly carried out.

Such patients have been frequently in the past, and, I am afraid, still are, the subject of unsuccessful operation. For example, how many cases of so-called chronic appendicitis are relieved only for a very few months, or less, by appendectomy. The case which is diagnosed as chronic appendicitis is, in my opinion, usually a sufferer from the colonic complex which I have demonstrated. Some have been repeatedly operated on for supposed lesions in other parts of the abdomen or for supposed, and often actual, adhesions after previous operation. Many become operation addicts. Small blame to physi-

*One of three addresses given by Sir Henry Gray before the Halifax and Pictou County Medical Societies.

cians who are sceptical about the value of *any* operation in such people. In my experience, however, operation, if not too long delayed and consisting of what I call a "spring cleaning", has been eminently satisfactory—in fact, I look upon it as one of the most satisfactory in results of any type of operation that I have done. With a better appreciation of the pathological import of these derangements and as a result of improvements in details of technique, each year provides an increasing percentage of good results.

Successful treatment of disease is the great factor which may help our profession to hold its own against academically unqualified competitors. The basis for intelligent treatment or even discussion of any trouble must include knowledge of its cause.

I have submitted, therefore, the series of lantern slides illustrating a contribution to our knowledge of the colon and an effort to point the way to more radical and, I venture to think, more common-sense methods of treatment of many disorders, general as well as intra-abdominal.

The common-sense aspect is indicated in the question—"Is it not better to eradicate the primary cause, if possible, while treating the end result"?

My thesis is this. The health of the body, as a whole, is dependent mainly on the capacity of the alimentary canal, the *prima via*, to furnish proper, healthy, nutritive material to the various tissues and organs of which that body is composed. The strength of a chain is dependent on its weakest link! If the integrity of any part of the alimentary canal is impaired, that disability is reflected, sooner or later, on the health of the individual. Any tissue or organ or chemical process of the body may then become inefficient, even to such an extent as to concentrate attention on it alone. But why treat the result alone and not the original cause?

Arbuthnot Lane irreverently called the colon a "cesspool"—a reprehensible term. But I have come to believe, with Lane, that this part of the alimentary canal has more influence than any other organism on the health and integrity of the tissues and organs of our bodies, whether these be intra- or extra-abdominal. Man's colon has, in a large proportion of individuals, lagged in accommodating itself to the assumption of the erect posture. In these individuals the anatomical arrangements of the colon resemble, more or less, those found in an animal, such as the deer, which "goes on all fours". All would be well if most of such individuals would exercise in that posture for a goodly part of each day, as they do in the earlier years of life. The effects of drag of loaded and unnaturally loose parts of the colon assert themselves when the upright posture becomes habitual, that is, when kept up practically without intermission during the whole day. In such cases Lane's expression may often with justice be applied to the colon. While symptoms usually begin to become manifest during the earlier half of the third decade of life, i. e., 20-25, a little consideration

renders apparent the fact that they may be well-marked in early life or postponed to more advanced age. I would repeat that severe abnormalities in anatomical arrangement are responsible for early symptoms, while, in less severe abnormalities, habits of life and maintenance of good tone, especially in the muscles of the abdominal wall, tend to defer the onset of symptoms. Change from active to confined mode of life, illness, stretching of the abdominal muscles, for example by pregnancy, may give the chance to these hitherto latent evil conditions in virtue of laxity of these muscles and therefore loss of their hitherto preventive support, with resultant change from good health to bad. Once the breakdown occurs it may be impossible by ordinary means to restore and maintain good health.

Some medical men are content to diagnose a symptom and to treat that!

Our efforts must be, in justice to our profession, to wean, or if necessary, blast men from this rut, and at the same time be constantly on guard that we are not equally guilty of the same offence.

We are talking about intra-abdominal derangements. I believe that the extrinsic anatomical derangements, the development and results of which I have tried to illustrate by lantern slides, are the primary cause, directly or indirectly, of the majority of maladies on account of which the general surgeon opens the abdomen. Several surgeons have shown that, in effect, these derangements mimic other lesions such as gastric or duodenal ulcer, appendicitis or cholecystitis. I am increasingly inclined to believe that beyond this mimicry, they are the cause, directly or indirectly, of many, if not of the majority, of the lesions themselves.

Arbuthnot Lane wrote in classical manner with regard to the effect of intestinal stasis on the tissues throughout the body and stirred up much interest which has been choked off in most quarters by absorption in other scientific matters. Let us get back to a broad viewpoint which includes all these details.

I repeat that on the integrity of the gastro-intestinal canal is dependent the supply of healthy, adequate nutrition to the body as a whole and to its various tissues and organs in particular.

If the anatomical arrangements of this canal are defective, and we are to-night considering only derangements produced by extrinsic causes, the proper discharge if its functions are, to say the least, precarious. Such extrinsic factors result in *abnormal mobility* of the affected area—a normally fixed part is loose or a normally loose part is fixed. This departure from normal mobility is soon reflected in *abnormal mobility*—usually greater effort on the part of the intrinsic muscular wall of the bowel is required to propel its contents onwards, that is, because a variable amount of stagnation must be present. Hypertrophy and dilation are the usual results. Interference with secretory powers follows. *Faulty secretion* plus *stagnation* beget *faulty digestion.* Purely chemical, as well as bacterial deficiencies in

the food stuffs, are the result and therefore, abnormal chemical changes in both cells and body fluids. Imperfect nutritive materials are supplied to the tissues and organs of the body. When stagnation is prominent toxic effects are likely to be most in evidence. The prostrating effects of absorption of duodenal contents in cases of high obstruction indicate that the absorption of abnormal purely chemical materials, resultant from the conditions we are considering, may be equally important although usually less obtrusive or more insidious.

How often do we treat the result in disease processes and not the cause? True it is that, in cases under present consideration, constipation is recognized and treated but aperients—evacuants of the bowel—whether administered by the mouth, under the skin, or per rectum, do not *remove* the most usual cause of constipation, which is faulty anatomical extrinsic conditions. Such remedies act as a whip does to a horse. A spirited horse responds to the slightest touch and makes an effort compatible with his strength, but the sluggish animal usually requires fuller and more varied application of the stimulus as time goes on. With the sluggish human individual, that is, in one who has lost tone, changes must be rung on the amount and kind of laxative medicines and on the amount and kind of mechanical bowel washes. Think of the life of the individual who is recognized as suffering from obstinate and chronic constipation. To greater or less extent his mind is diverted from ordinary and pleasant activities and is concentrated on getting his bowels to move. He is rendered miserable as well by sordid introspection of the various and variable other dysfunctions of his bodily parts. Why should we wait for the onset of severe symptoms before we attempt to treat mechanically those mechanical conditions which medicines will not remove? These conditions are easily recognized, and so when they are present one can venture to make a fairly reliable forecast of how the digestive system will behave under various conditions. A patient who has constantly to compensate for disabilities of his alimentary canal can not possibly lead a normal life.

I would here point out that constipation is not by any means invariable in sufferers from these derangements. Stagnating contents may cause such irritation that diarrhoea results. During, or just previous to, bouts of diarrhoea, symptoms, both local and general, may become more pronounced. In a few cases, the bowels move regularly. But in cases where general symptoms are present, the colon possibly never becomes properly emptied, and many patients are aware of this fact.

I would also point out that besides the mechanical and chemical effects of these anatomical derangements, there is, in some cases, a very definite reflex effect by drag on the various sympathetic plexures in the upper abdomen. Such patients frequently suffer from vague epigastric discomfort. They don't know how to explain their feelings but usually are quite definite that they are relieved and keep well

when they assume and maintain for the greater part of the day at least, the supine or prone position.

It is hard to convince the profession concerning the importance of these anatomical derangements. Lane laboured hard to show the importance of intestinal stagnation and consequent toxaemia on the local and general health, but in ascribing the formation of the various bands to the effects of stasis, he put the cart before the horse. These developmental bands are the *cause* of stasis, not the result.

I go the length of saying that a large number of general disorders, including those of endocrine glands, and a still larger number of abdominal disorders are due to them. In any persistent illness I urge the establishment of the presence or absence of the derangements I have discussed. The diagnosis is easy. If they are found to be present then their possible bearing on the disease in question should be taken into consideration. One may be called a crank on this subject but the company of cranks is steadily growing larger and already there are many outstanding men in its ranks.

As an example in this connection, let us consider the numerous symptoms in connection with the stomach which are diagnosed and treated at the present day. Hyperchlorhydria, achlorhydria, gastric neurosis, dyspepsia, achylia gastrica and so forth, in which diagnosis and treatment also, are too often merely a matter of a clinical equation established in the laboratory. Some one has said that "the stomach is the biggest liar in the body". Dwyer and Blackford recently stated that, in patients with gastric symptoms, the stomach is not the primary cause in 80%. A very large number of the cases cured by "spring cleaning" have been diagnosed and treated for years as a supposed gastric malady which was found not to exist.

In view of what I have said already I do not propose to discuss other than the objective symptoms—the physical signs—of these derangements, by which they are usually easily diagnosed. Descriptions of some of these, so far as I know, have not been published in books.

We must remember that there are three main outstanding features (1) dilatation and usually hypertrophy of at least some part of the colon, (2) abnormal fixation or abnormal mobility of certain parts of the colon and (3) the presence of more or less fibrous but peritoneal covered bands or adhesions connected with the colon or structures immediately to it.

It is easily appreciated that symptoms, both subjective and objective, may and do vary greatly according to the condition of the bowel and amount of its contents, the position of the patient, the amount of exercise taken, the character of food ingested, the general tone and feelings of the patient and even the state of the weather. Thorough evacuation of the bowel usually brings relief. Equally can it be appreciated that vicious circles, both mechanical and chemical, assert themselves from time to time, so that spells of discomfort or

suffering and of lowered general health may occur without specific reason. Hence the frequent impatient attitude adapted towards the complaints of these people and their derogatory relegation to the ranks of hypochondriacs, neurasthenics and so forth.

There are two types of individual who may suffer from these anatomical derangements. Of course the types merge into each other. At one end of the scale is the most common and usually most severely affected, the long, lean, "wasp-waisted" type, with lower abdomen bulgy in contrast with the upper abdomen. At the other end is the person with short, flat abdomen inclined to stoutness. The former type suffers mostly from downward drag and is frequently relieved by lying down, the latter may suffer most severely in the horizontal position when the abdominal muscles are relaxed and allow the gas-distended proximal colon to bulge forward and drag on parieto-colic bands often found about half way up the ascending colon.

Apart from objective symptoms already hinted at, I wish to point out particularly certain signs which, in my experience, can usually be elicited and are more reliable even than X-Ray films.

One differentiates *tension tenderness* from *pressure tenderness.* An inflamed or highly distended viscus is usually revealed by the tenderness which is complained of when pressure is made over it. To explain what is meant by tension tenderness:—let us take the adhesions which frequently exist between an otherwise normal gall-bladder and the adjacent colon, what some have designated as a ligament, the cystico-duodeno-colic ligament. Incidentally I think it is wrong to call such an abnormality a "ligament". Here pressure in a backward and upward direction, as is ordinarily done when trying to ascertain the condition of the gall-bladder, causes no discomfort. Indeed it may relieve a previously existing discomfort. On the other hand, after sliding the skin upwards and insinuating the fingers beneath the edge of the liver and then making traction downwards so as to move the transverse colon in that direction, the patient will experience a more or less sharp pain. Other subhepatic adhesions can sometimes be differentiated in the same way. Of course pressure tenderness and tension tenderness may coexist if the gall-bladder is inflammed. The narrower the band of adhesion the more easily usually is tension tenderness elicited.

Similar remarks apply to the diagnosis of adhesions in other parts. The mesosignoid adhesion may be present to larger or smaller degree at any part of the course of the sigmoid across the iliac fossa. The sigmoid is usually irritable when such adhesion is present and can then be felt as a painless sausage shaped swelling when palpation is made with the fingers at right angles to its long axis, tips of fingers towards the embilicus. On palpating with the fingers parallel to its course it cannot usually be detected, a fact which helps to eliminate the presence of inflammatory tumour or new growth. When the skin over the sigmoid is pushed towards the iliac crest, the tips of the fingers

are sunk into the iliac fossa and an endeavour made to draw the sigmoid towards the umbilicus. If adhesion of the mesosigmoid to the iliac fossa is present, the patient will experience a sharp pain when it is pulled upon—tension tenderness. The narrower and shorter, and more noxious, the adhesion is, the more intense and more easily elicited will this tenderness be.

I need not describe Gray's sign again, but would repeat that it is diagnostic of either a Lane's terminal ileal membrane or a submesenteric appendix, and which, of course, may exist together. I can give no reasonable explanation of the phenomenon.

The physical signs in the right lower quadrant are, naturally, most easily made out in a thin patient with a flaccid abdominal wall. A thick, muscular abdominal wall may entirely defeat the examiner.

The size, position, outline, mobility, nature of contents and tone of the caecal end of the proximal colon can often easily be made out. One can frequently feel, during deep palpation, that the colon contracts into a hard, tumour-like mass, but the contraction disappeared again usually within a minute or two. One can often ascertain the free mobility of this mass.

In some cases I have appreciated a feeling of vacuity in the iliac fossa when compared with an elusive fulness higher up in the flank. When this is present and when the percussion note of the upper part of the area normally occupied by the ascending colon differs from that of the lower part one can deduce with fair accuracy that an undescended caput caecum is present.

When parieto-colic bands are present they give rise to tension tenderness, more or less easily elicited according as the band is narrow and short or broad and long. Sometimes the patient is able to state that the tension tenderness resembles the dragging sensation which he ordinarily suffers from. Tension tenderness is found most frequently in two situations. (1) When the caput calcum is displaced in an upward direction, the tenderness is due either to bands of adhesions between the under and back part of the caput and the iliac fossa or sometimes to a Lane's membrane. (2) When the ascending colon is drawn inwards, the tenderness is due to a parieto-colic band which frequently is attached to the bowel about the level of the umbilicus. The appendix may be mixed up with the subcalcal or submesenteric adhesions and if inflamed may give rise to pressure tenderness also. The appendix is, however, often retrocaecal or retrocolic in position. One may then be able to ascertain that the pressure tenderness over the appendix differs in character from the tension tenderness obtained in either of the two situations mentioned.

By apportioning proper value to these various objective symptoms and giving reasonable consideration likewise to subjective symptoms, one can picture with wonderful accuracy in the great majority of cases, the condition of the patient's colonic attachments.

An X-Ray examination after a barium enema is necessary to show elongation of the colon and is useful for confirming the suspicion of such conditions as non-descent of the calcum but otherwise I must say that it does not help much. I have shown the necessity for taking films in the upright as well as in the horizontal position.

I do not propose to go into details of medical treatment, whether conducted inside or outside institutions, by drugs or colon washes, by diets, by methods aimed at getting the patient to become fat, by massage, by electrical currents, by exercises to increase the tone of the abdominal muscles, by abdominal supports, or other remedies. None of these treat the actual cause of the patient's ailments so that their success may be merely temporary and is always problematical.

I do not think that surgical treatment should be long delayed if these less certain procedures are not successful. Patients get into a habit of ill-health, become discouraged and lose faith in the profession. Disease or dysfunction may become so well established either in the abdomen or in any other part of the body that removing the original cause does not remove the secondary disability. Mechanical defects require mechanical adjustment. An engine runs badly and often breaks down under strain when its fuel supply is faulty. Prevention is better than cure.

When the physical signs, the stigmata, of these derangements are found, never neglect to give them full consideration. You will often be astonished at the excellent effect of operative treatment. While experience makes me talk thus enthusiastically in favour of operation in preventing or banishing ill-health, I would warn against it being undertaken lightly or by unpractical surgeons. To anyone who does attempt it I would say—make such a long incision that you can see every step easily. Under proper conditions an incision of 8-10 inches ought to heal as well as one of half an inch.

If a girl is good, she is good; and if a girl is bad, she is good—company.

An old maid in silk underwear is like malted milk in a champagne bottle.

Mandy, who had been troubled with her eyes for some time, finally consented to consult an oculist. He shook his head at the conclusion of the examination.

"You have been color blind for years," he said.

"Mah, goodness!" gasped Mandy. "Will you please go out an' see if dat's a Chinaman in mah car. I was married las' week an' no real nigger evah does laundry lak dat little guy."

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Canadian Medical Association Meeting

THE recent meeting of the Canadian Medical Association held in Montreal, June 17th to 22nd, was notable in a number of ways. In the first place it was noted that on Monday and Tuesday a larger number of members of Council were in session than at any previous meeting. This meant that the business affairs of the Association were so important as to make this large representation necessary.

From the scientific standpoint the meetings on Wednesday, Thursday and Friday were most comprehensive. These meetings were both sectional and general. It is also to be noted that our Montreal hosts were most hospitably inclined, and those visitors who had the time to spare were the recipients of many courtesies.

One is struck, therefore, with the immense number of matters that come up for consideration in the business sessions of the Council. It is only possible for us to very briefly call attention to some of the matters that were considered at the meeting.

The first report to be received was that indicating those members of our Association who *passed on* during the year that was just ended. Many of these we note who have some sonnection with Nova Scotia or who were well known to many of us. Dr. R. J. Blanchard, of

Winnipeg, formerly of Truro, Nova Scotia; Dr. J. H. Duncan, Chatham, N. B.; Dr. C. S. Marshall, Bridgewater, N. S.; Dr. F. H. Mewburn, whom many of us knew Overseas; Dr. P. D. McLarren, of Halifax; Dr. W. D. Rankin, of Woodstock, N. B.; Dr. C. L. Starr, of Toronto; Dr. F. J. Shepherd, of Montreal; Dr. M. T. Sullivan, of Glace Bay, N. S.

This meeting more than any other meeting that the Canadian Medical Association has ever held, was characterized by the large part that was taken in the programme and in the business of the session by the French members of our profession. Also these French members were very prominent in extending courtesies to the visiting physicians.

The report of the Executive Committee brought up a number of interesting matters. Great Britain was interested in the meeting in having two official representatives present. France and Italy each were represented by very prominent professional men. The Annual Meeting of the B. M. A. this year will have Doctors Harvey Smith, of Winnipeg, Bazin, of Montreal, Primrose, of Toronto, Fahrni of Winnipeg, Birkett of Montreal, FitzGerald, of Toronto, and Ramsay of London, representing the C. M. A.

The definite announcement was made by the General Secretary that negotiations between the Association and the Canadian Life Insurance officials had been completed so that the Association would take up the matter of periodic health examinations. The entire correspondence and forms to be used were presented to the Council and it is expected that the work will be officially under way January 1st, 1930.

The Association was also assured that for the fourth year $30,000 will be available from the Sun Life Assurance Company for Post Graduate Medical Education and $15,000 available for Hospital Services. It is certainly a matter for congratulation that sums of this amount are available for these purposes. Very extended consideration was given to the proposed establishment of the Royal College of Physicians and Surgeons of Canada. Also the operation of the Royal College of Surgeons of England for primary examinations in Canada.

Rather extensive consideration was given to the financial standing of the Association. Following the steps made in 1921 in order to put the Association on a sound financial basis the condition has steadily improved until to-day the Association has a total surplus of over $28,000. This, of course, has nothing to do with several Trust Funds that the Society is concerned with.

There was one rather sad incident in connection with the business of the meeting being the reception of the resignation of Dr. A. D. Blackadar, the Editor of the Association Journal. A suitable resolution was passed by the Association expressing appreciation of his very valuable services to the Society during the past ten years. We regret that at the time of our visit he was still suffering from the effects of an attack of Broncho-Pneumonia but we are glad to be assured that he

was well on the road towards recovery. BULLETIN readers will be glad to know that Dr. A. G. Nicholls, formerly of this City, has been appointed Acting Editor.

What has been said regarding the financial condition of the Association applies equally well to the finances of the Journal and Dr. A. T. Bazin received many compliments regarding his managership. A very considerable discussion developed from the report of the committee on Ethics regarding the giving of anaesthetics by nurses. Opinion was certainly divided and no definite conclusion was reached.

A very lengthy session was held by the Intra-Canadian Relations Committee. The resolution being that there was a very considerable amalgamation of committees with the idea of doing away with overlapping, etc. There was in the entire business discussion for two days definitely recognized that State Medicine to use the general term was something that the profession in Canada must be regarded as of immediate concern. Very considerable attention was given to this matter coming up from time to time in the discussion of general business. It was freely stated that the Canadian profession should not be taken unawares, and that a very full survey should be made of the entire situation so that we shall be able to indicate to the Government what is desirable in the way of State Medicine. The point was very clearly brought out that what the profession desire to know was what was in in the best interests of the people. There was an entire absence of any references whatever to the interests of the doctor. It was perhaps the most altruistic discussion ever held by any scientific body.

Very considerable attention was given to the 1930 Annual Meeting, which will be held in Winnipeg, in August, under the auspicies of the British Medical Association. There will be several hundred British Medical men and their wives in attendance at this meeting, and an effort will be made to have them see as much of Canada as it is possible. There was, however, a glaring neglect of suggesting that these people visit the Maritime Provinces. It would appear that some of the Tourist Associations that we have in the Maritimes might take up this matter of a visit by these distinguished guests to the Maritime Provinces. The various Provincial Associations were requested to start immediately to work up an interest in this annual gathering. There is certainly no reason why Nova Scotia might not furnish sufficient number of delegates to have one or more special cars. It should be noted that if one prepares in advance to take in a convention of this kind that it is much easier to get away when the time arrives. It is expected that the Prince of Wales who is Patron of the C. M. A., will also be in attendance at this Convention.

A very full and free discussion of the question of membership in Provincial and Canadian Societies took place at one of the meetings of Council. The opinion was expressed that Provincial membership was absolutely necessary for membership in the C. M. A. Association or its Council and Executive.

In this discussion the impression seemed to be general that almost 50% of the medical men in the province did not belong to the Provincial Society or the Canadian Medical Association. This was rather surprising to the writer because in Nova Scotia plus 95% of the medical men belong to the Branch Societies. Plus 85% of the men available for membership in the Medical Society of Nova Scotia are making their membership effective last year and this year and 60% of the men available for C. M. A. membership have made their membership effective. It was largely admitted that this was about the best showing for any of the provinces.

The general matter of full time Field Secretaries was very fully considered. The C. M. A. endorsed the idea of Field Secretaries on a basis of the C. M. A. paying 60 per cent of the cost and the Provincial Associations 40%. Already this plan is effective in Quebec, Ontario, British Columbia and is materialising in Manitoba and the Prairie Provinces. It was intimated quite plainly by representatives from New Brunswick that the Maritime Provinces should be zoned together under one General Secretary. This does not mean that Provincial Societies will be amalgamated. The idea is rather that each Society will maintain its own identity with, if necessary, an Honorary Secretary.

It is impossible in a brief report of the work of the Association to adequately cover the various subjects that were considered yet it seems necessary to make some references to these while the meeting is still fresh in our memories. Perhaps in a subsequent issue some member of our profession will give us some notes on the scientific programme that was presented. It was a splendid meeting, but two or three days were very hot.

S. L. W.

A recent wedding that was of much social interest was that of Miss Anne Helen, daughter of Mr. and Mrs. H. W. Cameron, of Halifax and Dr. Victor O. Mader, son of Dr. A. I. Mader of Halifax. The service was held at St. Matthew's United Church, Halifax, Rev. Dr. J. A. Clarke officiating. Mr. Allen Reid, organist at St. Matthew's, played the wedding march from Lohengrin as the party entered the church, played softly throughout the service and Mendelsohn's march as the party left the church. While signing the register Mr. Hubley sang "My Prayer". After the ceremony a reception was held at the home of the bride. After a short motor honeymoon trip they will return to reside in their own home in Halifax at 149 South Park Street. As the Doctor is such an ardent yatchman and aviator we expected the usual trip would be by one of these ways. We extend congratulations.

Branch Societies

HALIFAX MEDICAL SOCIETY.

BETWEEN the President of the Halifax Medical Society, its Secretary-Treasurer and the Secretary of the Medical Board of the Nova Scotia Medical Society BULLETIN, the meetings of the 1928 to 1929 sessions of the Halifax Medical Society have not been fully reported. A question may arise as to the responsibility of this failure. Let it be known at once that it is not on account of any falling down in the work of the local society by its President ot Secretary. We can say here and now that perhaps no one has occupied the Presidency of the Halifax Medical Society for many years as efficiently as has Dr. S. R. Johnston, very ably assisted by Dr. Gosse, the Secretary.

On the other hand, the Secretary of the Editorial Board does not feel he should take all the responsibility for not having these notes of the season's meetings appear at an earlier date. More than ever before he has been a victim of circumstances. He has been compelled to do and not do this and that and the other thing. To this extent he takes a certain responsibility for putting into one continued article a report of the proceedings of the Halifax Medical Society for the season 1928 to 1929.

In editing this he is indebted to the Secretary-Treasurer, Dr. Gosse, for the loan of the Minute Books detailing the events of the Society for the season just completed.

From the articles we learn that there was a meeting of the Executive of this Society on September 12th, 1928, at which most of the business appeared to be an effort to determine just who should or should not represent the local society on the Executive of the Medical Society of Nova Scotia.

A week later a tentative programme for society meetings throughout the season was adopted and with very little amendment was carried ultimately into effect.

The first regular meeting of the Society was held at the Lord Nelson Hotel on November 7th, 1928, with the President, Dr. S. R. Johnston, in the Chair. Some 40 odd members were present.

At this meeting Doctors Muir, Woodbury, Cunningham, Payzant and Lyons were elected to the Executive of the Medical Society of Nova Scotia.

Dr. Johnston delivered a most acceptable Presidential Address and the very efficient Secretary reports him as follows:—

"He stated that the confidence which the Profession inspires in the minds of the public has been shaken; that in consequence we are slowly drifting towards State Medicine, and that this danger is im-

minent because of our apathy towards the greater problems affecting the public welfare.

He dwelt at some length on the Cancer question holding that much of the fear of it, the near sense of disgrace which attaches to it in many minds, the terrible hopelessness associated with the name in the public mind is due to our failure to dissiminate our modern knowledge of the subject and to show to them that in spite of popular opinion great strides have been made in the treatment of this condition.

He supported his charge with the statement that where in other states the average period which elapses between the time of onset of symptoms and the date of consulting a physician is 8 months in this province it is 24.

He outlined the work now being carried out in Massachusetts in Cancer Control and while admitting that it might be too ambitious for us claimed that there must be some way of acquainting the public with our modern knowledge of Cancer.

He also discussed the matter of the institutional care of hopelessly advaced cases so that they may spend their remaining days where at least they may be spared unnecessary pain.

He next—following the same line of thought—spoke of the operations for Chronic Appendicitis and for Tonsillar infections, referred to articles in the lay press ridiculing operations for these conditions, and suggested that it was high time that the profession took a definite stand on the matter, satisfactorily demonstrating to the laity whether or not these procedures are justifiable.

The Chiropractor cult was next considered and cases cited which tended to show that the Chiropractor had something which the Doctor had not, this leading to the question "Would it not be worth while to investigate the claims of these men?"

The second regular meeting of the Society was held at the Nova Scotia Hospital, Dartmouth, on November 21st, 1928, at which over 30 members were present. At this meeting Doctors J. W. Merritt, H. D. Scammell, Clyde Holland, M. R. Irving, W. G. Coldwell, A. E. Doull, Jr., and Mary Stevenson, were elected to membership.

The scientific programme began with a paper by Dr. Lawlor on Dementia Praecox in which he reviewed the present knowledge of the subject, classifying and defining types and emphasizing more important medical and medicolegal features.

Dr. Hopgood then presented 9 female cases including Hebaphrenia, katatonic and Paranoia types of Dementia Praecox depressive and confusional types and several of doubtful diagnosis.

Dr. Morton next presented several male cases of Dementia Praecox showing mixed symptoms and spoke on the treatment of Dementia Praecox by manganese chloride intravenously in 5% Sol. He reported that they had treated 5 male cases—4 of Hebaphrenia type, the 5th in depressed condition of doubtful diagnosis, and that of these, three had gone home apparently well, and that the other two showed great

improvement. He stated, however, that the female cases treated had not shown such good results.

Dr. Johnston expressed the appreciation of the Society for the kindness and efforts of the staff and asked for discussion. This was engaged in by Doctors Forrest, Thomas, Payzant, Rankine and Lawlor.

The meeting was continued in the Dining Room of the hospital where a very excellent lunch was served. Speeches were made by Dr. Lawlor, Mr. O'Doyle the Business Manager, Dr. Johnston, and others. Dr. Rankine moved, Dr. Barton seconded, a hearty vote of thanks for the excellent entertainment. Carried.

An announcement was made that there was something like three minutes to catch the 11.30 boat, and the meeting adjourned in disorder.

Dec. 5th. 1928. This regular meeting was held at the Victoria General Hospital. 37 members were present.

Dr. Alan Curry presented case, male, age—fracture of femur, of history somewhat as follows: Man was walking in unfrequented place on a dark night and fell into a pit fracturing his femur. He remained there for three days and nights, without food or water and unable to attract anyone by his calls for help.

A friendly cow chanced that way and seeing him was so moved with pity that she couldn't take her eyes off him. There she stood through many weary hours figuratively wringing her hands in anguish at his plight, till her strange attitude brought some people to investigate who rescued him and sent him to hospital.

This case was said to be reported on the cow's account rather than on the man's.

Dr. Hogan then presented a boy of 8 who had a fracture of the hunerus between the greater and lesser tuberosities. He exhibited skiagraphs showing fracture in different positions before and after reduction, and stressed the required extension and abduction.

Dr. Murphy presented the following cases:—Casel. Case shown here 2 years ago, male, age 53, Gliooa c Rt. sided paralysis. Tumor was diagnosed clinically and confirmed by X-Ray. Operation was performed and tumor removed from left Parietal region. The skull was found to have been quite thinned out.

He has been quite free of symptoms till a few weeks ago when he began to have pain in the head. There is now a swelling at site of operation whose physical characteristics are those of a hernia cerebri.

There are now appearing the signs of increased intra-cranial pressure, which gives rise to the question what should be done for him? He expressed fear of attempting anything in region of tumor, but raised the question of decompression on other side. Felt personally, however, that there was nothing much to be gained.

Case 2. Boy of 7. Fracture of neck of femur, through base of neck of bone—probably mostly extra-capsular.

When put up in position instead of getting union absorption of the neck was found. This was allowed to go on till the process had ceased and regeneration begun. The point made was that in these cases operation should be avoided for a long time.

Method of treatment employed was that of Whitman.

It is found after 5 months, that there is a lessened angle between neck and shaft to about a right angle. Patient is not walking and will not be allowed to walk for three or four months.

Case 3. Admitted to Ward to-day, male, age 26, lump in neck under left sterio-mastoid muscle. Patient gives history of gone to bed 6 weeks ago quite all right, and of waking up in the morning with this lump. Feels well, has no temperature. Leucoyctes 7600 Diagnosis questionable.

Dr. Mack then presented two cases. Case 1. Male, age 77, farmer. Complete ulcer left ear. Began 1½ yrs. ago, when cutting a tree, axe slipped and cut his right ear. Soon a lump formed which ulcerated and extended down the face in front of ear. Process had burrowed deeply about external auditory canal and towards the mandible c sinnses. This has been treated by diathermy c improvement.

Case 2. Admitted for piles—operated on and recovered but developed retention cystoscoped week ago difficult to see anything. Cystoscoped to-day shows infiltrating ca. of prostate.

Dr. O'Brien for Dr. MacDougall, presented history of case of swelling around a superior molar tooth size of a bean. Dentist pulled the tooth but lump continued to enlarge. Some weeks later it was seen by a doctor who opened it. It bled freely. When admitted there was a swelling on alveolar margin soft and of deep red color. Biopsy was done and report by Dr. Smith showed Giant cell tumor. At operation it was found to have extended into the antrum.

Chief point to be made was that all that was needed was Excision and curretting.

Dr. Burris presented a modification of Young's Decompression Apparatus in which he claimed improvement on two points (1) Prevention of urine from passing into the antisiptic solution reservoir and (2) prevention of air from interfering with the proper functioning of the system.

Discussion of these various presentations was then taken up.

Dr. Curry's Case—Bone Plate.

Dr. T. B. Acker spoke of Bone Plate said all are agreed that plates should be removed as they always cause trouble and asked Dr. Curry when he would remove them.

He wished also to know if the locking could not be done by manipulation and so prevent necessity for plating. Also, when he expected to have patient walking and if caliper is likely to be applied.

Dr. Curry had left the meeting, Dr. Murphy replied. The turdency of surgery is to avoid open operations as far as possible. In

a young patient if one is driven to operate, Kangaroo tudor and plastic cast is sufficient. All cases, however, are to be judged on their own merit.

Regarding the plate. He would leave it alone for the present—probably indefinitely unless it began to cause trouble.

Dr. Hogan took exception to the statement that plates always cause trouble. He has cases of plated femurs which show that in a muscular thigh plates may remain indefinitely without trouble. Regarding time patient should walk, he believed that they should be allowed about early with Thomas' Caliper splint.

Dr. Lyons made some remarks regarding shock in thigh operations.

Dr. Hogan's Fractured Humerus.

Dr. Lyons, Dr. Kirkpatrick and Dr. Burris engaged in discussing this, the use of airplane splint, the fate of the tuberosite and the method outlined by Dr. Hogan being the Thomas method—rather than that by weight and pulley being the points covered by them.

Dr. Murphy's cases.

1. Glioma—Dr. Mader (V. O.) thought case should now be operated to reduce intracranial tension. Suggested that at operation ventricle should have needle put in to see if under tension and then asked if would consider doing a third operation below the tentorium. He also asked if would consider filling the ventricles with air to assist localization.

Dr. Murphy replied dealing with points raised, stressed the importance of early decompression operations in tumor cases, quoting a case which showed improvement c. decompression but in which much permanent damage remained. He had not decided what he would do further for this case but in view of its general nature he did not think it would be anything very extensive.

Case 2 and 3 received little comment thought in connection c the latter everyone seemed to question of the truthfulness of the sudden appearance of the swelling.

Dr. Mack's cases—Laudatory comments from Dr. Murphy regarding Diathermy as shown by Dr. Mack in this and similar cases.

Dr. O'Brien's case.

Dr. Smith presented specimens.

2 of Giant Cell Tumors.
1 of Fibrous Epulis.
1 Giant Cell Sarcoma—Head of long bone.
1 showing osteogenic sa.

but in view of lateness of hour reserved comment.

Few other remarks by Doctors Kirkpatrick, Woodbury and O'Brien closed this part of the programme.

The meeting was then invited to the Nurses dining room by Supt. Kenney where a very excellent supper was served and enjoyed.

Jan. 16th, 1929.

The record of the first meeting in 1929 is under date of January 16th and was held at the Dalhousie Public Health Centre. The minutes read as follows:—

Dr. Johnston, President, in the chair. The attendance being 22. The meeting was addressed by Prof. A. Stanley Walker, who gave a very interesting talk entitled "Vestigia". The lecturer dealt chiefly with features of life in the middle ages and traced the development of modern ideals in politics, trade and science from that time. He emphasized our indebtedness to the Greeks for many of our present day modes of thought and scientific methods.

A vote of thanks was moved by Dr. A. MacD. Morton, and seconded by Dr. Morrison, both of whom expressed their great appreciation of the most interesting lecture. Carried with great applause. The meeting adjourned after Prof. Walker had answered several questions by members.

The next meeting was held at the Victoria General Hospital on January 30th, 1929. Thirty members being present. The matter of Senior Life Membership in the Canadian Medical Association was considered by the Society in a letter from the General Secretary of the Provincial Society.

The Committee of one, Dr. W. L. Muir, was appointed to present a Report on this matter. At a subsequent meeting Dr. Murdoch Chisholm was selected to receive this recognition and his nomination has been duly passed to the General Secretary of the Canadian Medical Association.

The scientific part of the programme was then begun by Dr. Carney, who presented three cases.

Case 1. Male, 64, with obvious signs heart failure. Divides H. D. into 6 groups.

Congenital Rheumatic (which shows up before 45) Thyroid Hypertension (which shows signs before 50).

Syphilitic and Senile.

His case has deficient knee joints, plus plus, X-Ray shows aortic aneurysm.

Rheumatic heart breaks and murmurs, may be many times, syphilitic heart, once broken always broken.

Case 2. Male, 72. Shortness of breath, loss appetite, Dysuria, cough, extensive calcification of arteries, B. P. Few rales chest, otherwise negative, but investigating for cause of mild persistent temperature found by X-Ray extensive T. B. with cavitation.

Case 3. Female, 45. Came in for infec. arthritis hip treated surgically and did well. Then complained pain about knee, then ankle but, there were no signs. Then pain in toes 1 and 2 one foot, no signs. Week or two later toes became red—no temperature. Diagnosed erythromalalgia. Condition rare—first discussed by Weir

Mitchell. Occurs with extreme changes of temperature and is early sign of nerve lesion. Condition not related to urticarial conditions but is to Herpes Zoster in that pain precedes signs. Differs from Raynaud's which is stmmetrical and helped by heat. This is helped by cold. Treatment given was Calcium Lactate and Strychnine. Plus cold.

Dr. K. A. McKenzie then presented four cases.

Case 1. Male, 47, showed inability to walk 10 weeks before admission, legs becoming cold and losing use of them. Showed paraplegia lesion level and D. V. This was shown as case of Spinal Syphilis in absence of tabetic or G. P. signs but with clear cur myeltic features.

Case 2. Male, age 28. Nodes in neck—none elsewhere—Leucocytes 18-24—Fever. Syphilis excluded, adenitis adherent. Node removed but pathologagy could not be definite. Very probably Hodgkins.

Case 3. Diabetes Insipidis 10 years duration sp. gr. 1000 practically, no urea 4% physical examination negative except for some little difficulty in speaking. X-Ray of pituitary region negative. Slight bi-nasal dimunition in acuity of vision but no bi-temporal which is the usual.

Case 4. Male, had left eye injury which necessitated removal. Two weeks later became deaf in one ear. Then monoplegia right arm numbness on that side of body. Then attacks stone blindness. For last year has vomited most of his meals. Condition has existed 14 months.

Objectively: anaesthesia limited strictly to mid line lower limit horizontal. Slight movement of arm with movement of fingers.

Diagnosis functional treatment light hypnosis was induced and arm restored. Deafness was more difficult at first but responded. Believed vomiting would respond similarly.

Dr. MacKenzie then gave a demonstration of patients susceptibility to suggestion, inducing hypnosis and showing his response to suggestions in that state.

The best feature of this meeting was the very general discussion that was carried on regarding nearly all the cases presented.

Regular meeting held Feb. 13th, 1929, at the Dalhousie Health Clinic. Some 25 members being present. There being no business, the scientific programme was at once begun. Discussion on Chronic Appendicitis—the leaders in which were to be Dr. Murphy, Dr. Birt and Dr. Weatherbe.

Dr. Murphy led off: The condition left after an acute attack has subsided. Fibrosis of greater or less degree, producing more remote abdominal symptoms, he thought should not be considered "Chronic Appendicitis", though it is frequently so called. He regards as more typical the following cases. Six years history of abdominal distress some disturbance of appetite occasionally a little nausea, having no

fixed relation to food—later becoming anaemic—quite intelligent type. Thoroughly examined. BbO2 anaemia of secondary type—no evidence of ulcer anywhere though blood in stool. No pain, no fever, X-Ray showed some suspicion of pylorospasm but none of ulcer. After rest in bed for weeks with treatment for the anaemia, the abdomen was opened. There was no evidence of ulcer, but the Duodenum showed slight redness. The appendix of the string of beads type, not bad looking, was removed. Patient improved rapidly all distress cleared up. HbO2 improved rapidly and patient is to-day living a busy life.

Type 2. He styled "The psychogenic type of Chronic appendicitis. Pale anaemic type of girl—finicky appetite, constipated and with a pain in the side. He believed this to be the type of case which brings most discredit on the surgeons. The greatest diligence on the part of the surgeon must be exercised in this type of case.

Type 3. This type characterized by moving Gastric distress without relation to food, and with occasional pains in right Iliac Fossa should be regarded more seriously.

Discussing these types he said that in type 1 the reflex action from the appendix causes toxaemia, which, acting on the gastric mucosa, produces small haemorrhages. The flush on the duodenum, also due to toxamia, is regarded as being almost pathognomonic.

The type 2, he said, if removed it is the beginning of a very vicious circle. They are at first improved—which is psychic, then begin to have pains again. A scar is found, adhesions are said to be the cause—they are re-operated and the last state is worse than the first.

Regarding pathological reports in these cases they are not helpful, that appendices removed incidental to other abdominal work, apparently normal, are reported as chronic appendicitis. In older patients, too, he believed that many cases reported back as chronic appendicitis are no more than the filrosis of involution normal to it.

He concluded his remarks by stating that the best mental attitude to adopt in meeting alleged chronic appendicitis is that it is something else, till by exhaustive investigation all else is excluded; that pain alone is misleading and that if it is sufficiently definite due to appendicitis, there is to be obtained a history of nausea, however slight and without relation to food.

Dr. Birt then took up the question. He stated that the collation of results over recent years showed that chronic appendicitis was a condition demanding the greatest care in diagnosis—best met by proper team work. He quoted results in 400 cases, from the literature, in which 275 showed satisfactory results, but in which the remaining 125 the symptoms were either nonaltered or made worse.

He stated the cause of failure to be a double one. In some wrong diagnosis, but in most cases examination, diagnosis and operation were incomplete.

He would include as Chronic Appendicitis, everything but the acute. Interval cases should be done at 3 months since large per cent relapse in 2 years.

He mentioned specially a Chronic Dyspeptic type which later may show symptoms of ulcer, with c hyperacidity, haematemesis and distress and nausea without relation to food and frequency augmented by exercise.

He pointed out the importance of neuralgia pains along the dorsal nerves, often the sequel to infectious of the respiratory tract.

He believed cases to be recommended for operation are:

1. The intermittent cases.
2. The Chronic Appendix.
3. Children with chronic dyspeptic type, since the element of neurosis is absent.
4. Definite evidence that function of stomach or colon is interfered with, where no other definite cause can be found.
5. Certain families susceptible. Where chronic dyspepsia of the ordinary functional type does not respond we are justified in opening the abdomen.

He then enumerated and discussed methods for eliciting appendical tenderness; stated that hyperaesthesia as a sign was vitiated on the basis of lower neuralgias and recommended Barker's finger tip method of eliciting signs of rigidity.

Concluding, he believed team-work to be essential and that postoperatively these cases required to be followed up medically. He stressed care in incisions for the protection of all nerve filaments and stated that no man should operate unless he was prepared to do everything which may be required in the abdomen.

Dr. Weatherbe suggested that gastric symptoms may be due to chronic infection as such symptoms may arise from chronic tonsillar infection. Stressed the great need for extreme care in full examination of patient before diagnosing chronic appendicitis and the value of X-Ray especially the screen. He cited many cases cured by removal of appendix where symptoms were either parasites in children, TB joints, repeated miscarriages, nocturnal vomiting or continuous vomiting three months gestation.

The next meeting was held Feb. 27th, 1929, at the Dalhousie Health Centre, twenty-two members being present.

The scientific part of the programme was opened with the presentation by Dr. J. G. D. Campbell of a paper entitled "Paediatrics and the General Practitioner."

He first dealt with "Paediatrics" from its philological aspect, outlining its etymology and complaining of the improper spelling met with in the literature.

He treated the development of the specialty and its growth to social prominence in child welfare. He stressed the fact that paediatrics is, after all, the application of General Medicine to an age group. He

believed it to be essentially the work of the general practitioner and that the term Paediatrist should be used for merit alone.

He depricated the neglect of this branch of medicine by many men and suggested that before criticising the work of the Clinics we should see to it that we are not sending them there by our negligence. He stated that the advance in recent years is due to a change of attitude from ideas received at autopsy to the concept of it as a biological problem.

He spoke of the great importance of the mother's diet during the gestation period to the first few months or years of the child's life. Then to maintain perfection, it is necessary to see that the child receives breast feeding from a mother who is receiving the same general care as during the prenatal period—care as to appetite, diet, bowels, sleep, anaemia, malposition, subinvolution, cracked nipple, etc. Then for the baby careful weighing and stool inspection. If breast feeding inadequate, complement or supplement—other food and there modified animal milk is best. He deprecated the extension and indiscriminate use of patent foods.

He dealt with the pre-school age—from two years old on showing that the child demanded the same care, but almost never got it. Regarding the child of school age, he had no specific suggestions. Believed that they were generally being taken care of and that the general practitioner was doing the work of this group well. He said that where we are falling down is in preventive paediatrics.

He complained that Dalhousie is not turning out good general practitioners, because they are not trained in paediatrics. He said Paediatrics at Dalhousie was a "conglomerate mass without head or tail."

A most interesting and general discussion followed. We are glad to learn that this paper will be presented at the Annual Meeting of the Provincial Society.

March 13th, 1929, Dalhousie Clinic. Arrangements were made at this meeting for Sir Henry Gray, of Montreal, to present two lectures to the Society.

Dr. M. R. Elliott of Wolfville, was then introduced by the President and read a paper of two parts, the one entitled "The Diagnosis of Missed Abortion", the other "Some Indications for the Induction of Abortion in Hyperemesis Gradidarium".

In defining the term "Missed Abortion" he gave the definitions of Frankel and of Matthew Duncan, but held the former to be better, that is to say that missed abortion is the intra-uterine death of the foetus *prior to its viability* with the complete retention of the product of conception for the normal duration of pregnancy or longer.

The condition is said to be rare but he quoted DeLee and others in support of the opposite view. He stated that there is a great diversity of clinical manifestations, and cited two case histories of diverse order in support of that. He then engaged in a speculative discussion

of the cause of the death of the foetus, and of the question "Why does not the uterus expell the products of conception?"

In the latter connection he suggested as one answer, that if expulsion does not take place the pregnancy cannot be wholly dead, and therefore is not a foreign body; or another than an ingrowth of chorionic villi may take place into the musculature, weakening the walls and rendering it incapable of contraction.

Under treatment, he said that each case must be studied individually; that most cases clear up spontaneously while in others the indications for early surgical interference are clear with a warning in mind, however, that the uterine walls are thin and friable and the product of conception always more or less adherent.

"Indications for the Induction of Abortion in Hyperemesis Gravidarum."

At the outset he acknowledged the importance of a psychosis in many of these cases, but that after all the various measures have been tried—rest, isolation, a competent attendant, and suggestions and focal infections and uterine displacements taken care of, there still remains a group presenting more or less the following conditions. Intense concentration of the blood, pulse 100 or more, relatively low blood pressure, fever, haematemesis, jaundice, albuminruia, acitonuria, indicanuria or marked loss of weight.

He cited cases representing (1) those which brook neither argument nor delay, (2) the type in which the psycho-neurotic factor was dominant and (3), that in which it is more difficult to decide as to the propriety of action, but which often necessitates drastic measures.

He stated that this was introduced to provide the subject for general discussion and he wished to know what the experience of our members has been with the use of the Duodenal Tube and also with Insulin and Glucose solution in these cases.

The next meeting of the Society was held on March 27th, 1929, at Dalhousie Health Centre. Sir Henry Gray addressed the Society at 4 P. M. on the subject of Osteomyelitis. Medical Students of Dalhousie had been invited to this meeting, and the lecture room was taxed to capacity, about 175 doctors and students being present. Sir Henry gave a very complete paper on the subject which was illustrated by lantern slides. Immediately upon the close of that paper, he went on to one entitled "Should Drainage be Established". The burden of his theme in this paper was that it is rarely necessary to put a drain in an abscess cavity even if it should be in the abdomen. Advocates mopping out the pus till cavity dry and then closing the abdomen. Says non-drainage prevents complications and sequelae; that mortality in drainage cases is 9% and in non-drainage 5%.

He advocates big incisions so that every aspect of the part can be visualized. The Thoracic conditions he claimed that it was the recognition and practise of this principle of closure without drainage that changed the figures from nearly 100% to one of 70% saved.

Because of the great length of the meeting, discussion was negligible and meeting adjourned at 6.00 P. M.

At the Health Centre again at night Sir Henry Gray addressed the Society on the subject of "Common Anatomical Derangements of the Intestine Influencing Maintenance of Health."

This was very fully illustrated with lantern slides which showed the errors in development—chiefly in the matter of descent of the caecum involving the proximal and distal colon.

He claimed that the basis for symptoms which frequently lead to operations for appendicitis, cholecystitis—or lithiasis, duodemal ulcer etc. was to be found in this, and that, the treatment for it was always operation, which he demonstrated by slides.

April 3rd, 1929, Dalhousie Health Centre. An Executive and a special meeting was held early in April when consideration was given to the Dental Bill that was subsequently passed at the recent session of the Provincial Legislature.

April 10th, 1929, meeting held at Childrens' Hospital. Twenty-one members were present. Dr. M. D. Morrison presented a communication regarding the Osler Memorial Fund and it was generally thought that it might be dealt with through the C. M. A. Committee for that purpose. Scientific cases were presented by Doctors Curry, Weatherbe, Acker and Carney, some twelve or more cases being presented.

The Society extended to the staff and management of the Hospital thanks for the programme and for a pleasant luncheon held at the end of the meeting.

The Annual Meeting of the Halifax Medical Society was held at the Lord Nelson Hotel, **April 24th, 1929,** there being some 36 members present. After an excellent dinner had been served, a nominating committee was appointed who subsequently brought in the following nominations.

President—Dr. J. R. Corston.
Vice-President—Dr. J. N. Lyons.
Secretary-Treasurer—Dr. Gosse.

Representatives to N. S. Medical Society Executive: Dr. R. P. Smith, Dr. A. R. Cunningham, Dr. J. M. Murdoch, Dr. C. E. Kinley, Dr. E. T. Glenister.

Dr. Johnston then gave his valedictory in a very short speech thanking the executive and the Secretary for their co-operation, and hoped that the attendance, though having shown slight gain during year of his incumbrance, would show still greater gain in that of his successor. He then called Dr. Corston to the chair and retired to that of Past-President amid great applause.

The report of the Secretary-Treasurer showed that during the year 13 meetings had been held, 11 regular and 2 special. The average attendance at the regular meetings was 28.

It showed that two members were lost to this Society, Dr. P. D. McLarren by death, and Dr. E. Brison by resignation, but that 7 new names had been added—Doctors Merritt, Scammell, Holland, Irving, Colwell and Stevenson, and that the membership now stands at 98.

Finances. This showed our disbursements to have been greater than usual on account of the expense incurred in the erection of the tablet to the Founders of the Medical School.

Bank Balance	$92.15	
Current Dues due	82.00	
Arrears		$20.00

On May 10th, 1929, there was a meeting of the Executive which was held at the Pathological Building at 12.30 P. M., the President, Dr. Corston, in the chair. There was a full attendance.

The purpose of the meeting was to consider a suggestion made that this Society extend some recognition to Dr. George David Stewart of New York University, who arrives shortly in this city to receive an honorary degree from Dalhousie.

A committee was appointed to arrange for this event.

May 13th, 1929. Dinner at Ashburn Golf Club on May 13th, 1929, in honor of Dr. George David Stewart, Surgeon-in-Chief of the Third Division, Bellevue Hospital, Professor of Surgery, Bellevue Hospital Medical College, and a distinguished Nova Scotian.

The following menu was enjoyed by all:

MENU

Fruit Cocktail.
Celery. Olives. Rolls.
Cream Asparagus Soup.
Roast Lamb. Mint Sauce.
Mashed Potatoes. Creamed Cauliflower. Green Peas.
Crackers and Cheese. Bread and Butter.
Ginger Ale and Soda Water. Strawberry Tart.

After the toast to the King, Dr. H. K. McDonald was called upon to propose the toast to our guest, Dr. George David Stewart, a native of Malagash, Cumberland County, he has always been a stalwart advocate and friend of Nova Scotia. He spoke of his very great work in Bellevue Hospital. He felt that this toast would be equally heartily endorsed by the Medical Society of Nova Scotia, as he was one of the most distinguished Nova Scotians who ever left the Province. Dr. Stewart replied in a very pleasing address, and spoke very feelingly of coming home and was sorry he came so seldom. He also read some verse of his own composing, which we hope to read in the BULLETIN at a later date: "Yes! Plant me beneath the great oak tree."

Dr. R. E. Mathers proposed the toast to Dalhousie University to which Prof. A. Stanley MacKenzie, President of the University, replied. The record goes on to state that at an after meeting Doctors Johnston, A. McD. Morton, Burris and others, accompanied by Dr. Cunningham on his guitar rendered some highly classical (?) vocal selections.

ANNUAL MEETING.
WESTERN NOVA SCOTIA MEDICAL ASSOCIATION.

THE fifth Annual Meeting of the Western Nova Scotia Medical Society took place in the Kiwanis Club Rooms at Yarmouth on Tuesday afternoon, May 28th, at 2 P. M. with the President, Dr. J. E. LeBlanc, in the chair. Twenty-four of the members were present.

After the routine business was concluded a scientific address entitled "Goitre—Its Significance and Treatment" was given by Dr. Howard N. Clute, Surgeon of the Lahey Clinic in Boston. This proved to be a most interesting and instructive clinical address. It was interspersed with lantern slides demonstrating the different phases and types of Goitre. Dr. Clute opened his talk by saying that the normal Thyroid gland underwent hypertrophic changes in three periods of a woman's life, Adolescence, Pregnancy and at the Meno-pause. He then dwelt at length upon the Colloid type, the Adenomatous, the Exopthalmic and the Malignant. The phases by which the unoperated adenomatous type passed into the malignant was very clearly explained. He impressed the hopelessness of this type of malignancy and illustrated the importance of examining carefully by X-Ray etc. for the sub-sternal Goitre frequently missed in some physical examinations. Dr. Clute's dictum is that, with the exception of the simple type met with in adolescence, etc., once the diagnosis of Goitre is made the next step is to remove it. Dr. Clute dealt with the adenomatous type and the more prevalent Exopthalmic Goitre. He supported the various contentions with interesting statistics from the Lahey Clinic showing the results of the B. M. tests in periods from three to twelve months after operation, in both Primary and Secondary Goitres, with most satisfying post-operative statistical results. Dr. Clute's teaching is that Iodine should not be given except as a prophlactic and as a pre-operative medication. Given otherwise, it is Dr. Clute's opinion, that the great benefits obtained as a pre-operative measure are lost and for other types no permanent benefits follow its administration.

Following this Clinical talk some eight patients were presented in which Dr. Clute demonstrated different diagnostic signs and explained clinically these different types of Goitre. Among the cases shown were several N. C. A. cases and in these Dr. Clute demonstrated the difference between prominent glands in patients with thin necks whose symptoms were not due to any thyroid pathology and the differential diagnosis between these cases and Toxic Goitres was very clearly demonstrated clinically. Dr. Clute demonstrated several new clinical signs and particularly emphasized the value of the quadriceps test as a differential symptom between Exopthalmic cases and those of N. C. A. origin. In the discussion which followed Doctors Campbell, Burton and Webster joined.

A hearty vote of thanks was moved by Dr. Farish and seconded by Dr. Gullison extending the gratitude of the Society to our Guest

for his most instructive address. From the clear exposition of the subject as well as the well arranged slides and the very appropriate clinical demonstration of patients with almost all the different types of Goitre discussed in the address, as well as general neuresthenia. Dr. Clute's clinic proved to be one of the most instructive and completed one of the most pleasant meetings which our Society has had since its inception.

The election of officers was as follows:

President	Dr. A. R. Campbell, Yarmouth.
Vice-President for Digby	Dr. A. B. Campbell, Bear River.
Vice-President for Shelburne	Dr. L. P. Churchill, Shelburne.
Vice-President for Yarmouth	Dr. F. E. Gullison, Yarmouth.
Secretary-Treasurer	Dr. T. A. Lebbetter, Yarmouth.

Nominated to the Provincial Executive of the Nova Scotia Medical Society Drs. L. M. Morton, of Yarmouth and W. C. O'Brien, of Wedgeport. Auditors, Drs. Melanson and O'Brien.

OBITUARY

It was with sincere regret that members of the medical profession and many of the general public learned of the passing on June 11th, 1929, of Mrs Cox, wife of Dr. Robinson Cox of Upper Stewiacke. Early in the summer of 1928 she was a patient in the Victoria General Hospital making a good recovery after a serious operation. Influenza this past winter left her with serious heart lesions and she passed away following a stroke of paralysis. She lived a life time in Upper Stewiacke and was universally esteemed.

Besides our Honourary Member, Dr. Robinson Cox her husband, she is survived by two sons, William R. who is winning a fight over tuberculosis contracted overseas and Otis S. a civil engineer with the Department of Public Works. To Dr. Cox and his sons the profession extend sincere sympathy.

We regret to note the death the latter part of May of Harold Miller, 17 year old son of Dr. and Mrs. A. W. Miller of New Waterford. He was a student at Saint Francis Xavier college. Dr. and Mrs. Miller have the sincere sympathy of the medical profession.

Correspondence

PERNICIOUS VOMITING OF PREGNANCY.

I WILL make the startling statement that I have stumbled on a cure for pernicious vomiting of pregnancy!

I must qualify this statement by saying that my experience with the treatment of which I am going to speak has been limited to the experience which is gained in a moderate sized country practice, and that is not enough on which to make any very definite statements, but I will present it to you for consideration, and trial if you see fit.

During 1927 I was called to see Mrs. M—who was two months pregnant and was vomiting. I gave her the usual gastric sedatives with no results. After some time I decided that pregnancy must be terminated in order to save her life but to my horror I began to realize that, as these cases are so prone to do, she had slipped away beyond the stage where any operative procedure could be tried. Hypodermic treatment with corpeus luteum had no results. She was now four months pregnant, was emaciated, weighing 77 lbs. pulse running 140 to 160, tongue very thickly furred, skin not definitely jaundiced but very sallow. Apparently a hopeless case.

In going over the books again I ran across the sentence; The sedatives are best. I gave her this:

Pot. Bromid	grs. S. S.
Chloral Hydrate	grs. VII S. S.
Ext. Cannabis Indica	grs. 1/8
Ext. Hyoscyni	grs. 1/8

Three times a day.

In two days she had practically stopped vomiting, but she was at the time in pregnancy when vomiting sometimes ceases. However, when the bottle of medicine was finished she began to vomit again, but the prescription quickly stopped it. She had to take it at intervals during pregnancy but went on to term.

Mrs. MacC—had had a serious time with vomiting during a previous pregnancy and began to vomit most violently about the second month. Her only complaint after receiving this prescription was that it stopped the vomiting too suddenly. She did not vomit again.

Dr. Young will pardon me for quoting one of his cases. Mrs. G— had vomited until she was in a dangerous condition and termination of pregnancy was necessary. We procrastinated for a time until she also was not fit for operation. I induced Dr. Young to try my treatment which he did, I think very faithlessly. In a short time he told me that she did not vomit any more after taking the medicine.

Since that time I have given this prescription to every pregnant woman who complained to me of nausea. That has been a goodly number, and it did not fail to cure the nausea in one case.

We have two babies in our own home. My wife is a nurse and is well qualified to judge the effect of treatment. During her first pregnancy she suffered a great deal from nausea. During her last pregnancy one dose of this would drive the nausea away.

Another patient who is a nurse told me that it did the same for her.

In anusea or vomiting of pregnancy I now turn to this remedy as hopefully as we turn to digitalis in broken cardiac compensation.

This is put up by Frosst's under the name of Elixir Bromide and Chloral Co. Other firms have practically the same thing in hypnobyomic compound. It will not cure all the gastric ills of pregnancy, for there is a great deal of gastric distress which it will not touch, but the vomiting is the thing which kills and that is what we are most interested in.

If this remedy will turn out as well in your hands as it has in mine I think we will have something which will save life and save a great deal of suffering.

T. W. MacLean, M.D., C.M.
Scotsburn.

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DID YOY GO TO PICTOU—and bring home a prize for talking the best game of golf?

That Public Health concerns all the work of the medical profession is very fully brought out in an address at a Section meeting of the American Medical Association held in June 1928. It was the Section of Obstetrics, Gynecology and Abdominal Surgery. Incidentally, it was the 79th Annual Meeting of the American Association. The speaker said:—

"I shall have time only to consider our two most important problems; one in gynecology and one in obstetrics; namely, cancer of the uterus and maternal mortality, both real public health questions. Enough facts and procedures are known to reduce the deaths of women by thousands every year if the profession would only apply the knowledge it already has. Why, in the name of humanity, it does not or will not is an enigma."

Regarding Cancer of the Uterus he concludes:—"The specialist sees relatively few cases, the family physician many. Therefore the early diagnosis and prevention of cancer of the cervix uteri is distinctly the duty and great opportunity for service of the family physician.

If he would help the propaganda for the periodic examination, he would see ten women where he is now seeing one, and he could educate them to the fact that leukorrhea is always potentially a dangerous sign because it is a symptom of the condition which is the forerunner of cancer.

If he would properly treat all infected, lacerated cervices, he would materially reduce the incidence of cancer. If he would heed the early signs of cancer, take biopsies and curet for diagnosis, cancer would be detected earlier; and if he would see that there is no delay in treatment, more cures would result and we should begin to see a reduction in the mortality from uterine cancer instead of the present appalling increase."

Maternal Mortality is considered along several lines and concludes thus:—

"If the family physician who cares for at least 80 per cent of pregnant women will give them prenatal care, diagnose carefully the position and presentation, he meticulously aseptic, quit unnecessary intervention, especially in occiput posterior positions, never do an operative delivery before complete dilation, and at all times appreciate the dignity and high demands of obstretics, the maternal and baby mortality will drop at once. Failing in these, he may hear from the public when it appreciates the reason for the preposterously high and undiminishing mortality—for the health of the people is the concern of the state. Then we shall probably hear the wail of "state medicine" but this will never come unless the profession brings it on itself by neglecting to apply the knowledge it already has. There are enough lives lost which cannot be saved by anything known to medical science. May no more be added to these by neglect."

Perhaps the profession in Nova Scotia might take a more active interest in these and kindred matters definitely connected with mortality and morbidity statistics in Nova Scotia.

Locals and Personals

WHILE Dr. M. E. McGarry of Margaree Forks was attending to his Legislative duties in Halifax, Mrs. McGarry visited at her former home in New Jersey. The Doctor and Mrs. McGarry were recent visitors in Halifax.

Dr. and Mrs. R. J. Collins and two daughters of River Glade, New Brunswick, were recent visitors in Berwick.

We regret to learn that Dr. J. W. Barton, Halifax, was a recent patient in Camp Hill Hospital. We trust he has made a complete recovery.

Among recent medical graduates at McGill from Nova Scotia, we note but one—Dr. J. E. McArthur, Grand Mira, C. B. It is quite evident that our own Dalhousie University is appealing very strongly to our medical students.

A recent graduate from Mount St. Vincent, Rockingham, was Miss Alice Smith, daughter of Dr. T. H. Smith of North Sydney.

The medical staff of the Middleton Hospital was recently organized into a Medical Society, for the purpose of co-operating with the Board of Management of the Hospital and to hold monthly medical meetings. Dr. F. S. Messinger was elected Chairman, and Dr. H. E. Kelley Secretary. Doctors White, Morse, Sponagle and Graham were appointed a Committee to draw up by-laws.

Dr. and Mrs. E. D. McLean of Truro, who have spent the winter with their daughter in Florida, have returned home. We trust the Doctor's health has been greatly improved.

Mrs. M. T. Sullivan of Glace Bay, widow of the late Dr. M. T. Sullivan, accompanied by Miss Mary and Tom. recently motored to New York, where two sons are now living. To the great regret of many in Glace Bay, Mrs. Sullivan will make her future home in New York.

Dr. Philip L. Oxley, son of Mr. and Mrs. A. O. Oxley of Walnut Street, Halifax, a graduate of Dalhousie 1929, was married on June 26th, 1929, to Miss Christine G. Campbell of Providence, R. I. The wedding took place at the home of the bride's brother, Capt. F. D. Campbell of Pictou.

Dr. R. F. Harlow, Dalhousie 1929, has gone to Vancouver and will hold an internship in the Vancouver General Hospital for the coming year.

Dr. F. J. McLeod of New Waterford, has been on a recent holiday at his old home in Pictou County.

Dr. S. G. and Mrs. MacKenzie of Westville are at present in California. The doctor is having a three months vacation which he greatly needed.

Dr. G. M. Morris of the Department of Public Health at Trenton, Tennessee, spent his recent holidays with his father and mother, Dr. and Mrs. C. H. Morris of Windsor.

Life is like that—Eyestrain is caused by the other woman, earache by the wife.

Pat was spending the night in a haunted room. Suddenly a voice moaned: "There's only you and me, there's only you and me." "Begorra!" cried Pat, "there'll only be you when I get this other boot on."

My dear, I just heard a shocking story about your husband." "Tell me quick—I need a new hat!"

Dr. and Mrs. H. L. Scammell of Halifax, recently spent a short vacation in Pictou visiting Mrs. Scammell's parents.

Dr. Donald R. Chisholm returned in May from Midway Island, where he had been attached to the Cable Services for a year. He is a son of Mr. Dan. Chisholm, Armdale, and is now an Interne in the General Hospital of Victoria.

Congratulations should be extended to Dr. R. W. Kenney, son of Mr. W. W. Kenney, Superintendent of the Victoria General Hospital, in being made a Fellow of The Royal College of Surgeons, England. Dr. Kenney resides in London.

Airy Trifles. Irate Father—"I can see right through that chorus girl's intrigue, young man."

Lovesick son—"I know, dad, but they all dress that way nowadays."

"Anything besides collars, ties and handkerchiefs, sir? How about some nightshirts?"

"I ain't no society rounder, young feller; when night comes I go to bed."

Ayerst

Irradiated Ergosterol

Announcement

The remarkable Vitamin D activity of Irradiated Ergosterol has aroused widespread interest and we have received many enquiries from members of the profession for this substance under the Ayerst label.

The J. A. M. A., April 13, 1929, comments editorially on Irradiated Ergosterol as follows:- "In human infants a daily dosage of considerably less than 4mg. (6/100 grain) has already been demonstrated to be curative in cases of unmistakable rickets; and there is little doubt that this quantity may be considerably larger than the minimal protective dose. It should not be surprising, therefore, if larger quantities of such potent substances would exert a pronounced effect on the organism in directions that may not always be merely beneficial."

And further, "Hypercalcification (eburnation), abnormally high blood pressure and hypercalcemia need at least to be borne in mind during the present stages of educational adjustment to new therapeutic possibilities."

In the light of the above and similar comments, we have purposely delayed the marketing of "Irradiated Ergosterol, Ayerst", but in order to supply the demand our product is NOW AVAILABLE, prepared by the Steenbock process, physiologically tested and in a form which will at least minimize the danger of overdosage.

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Ayerst, McKenna & Harrison

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MONTREAL 71 WILLIAM STREET CANADA

Dr. and Mrs. Hugh McKinnon, of Berwick, spent a day recently in Halifax.

Dr. and Mrs. V. H. T. Parker of Stellarton, were recent visitors at the doctor's former home in Bridgetown.

Dr. L. J. Lovitt of Bear River, was a recent visitor to Yarmouth, going there to meet Mrs. Lovitt returning from several weeks' stay in Boston.

Dr. J. P. McGrath of Kentville, recently addressed the local Rotary Club on his experiences with (the) Scotch.

The marriage is announced of Mr. A. Blenus Morton, son of Dr. and Mrs. A. McD. Morton, in Toronto, June 29th, to Miss Agnes Cudhea, daughter of Mr. and Mrs. Robert Cudhea of Glace Bay, Nova Scotia. Mr. Morton is a graduate in Arts and Law. They will reside in Waterloo, Ontario, where Mr. Morton is associated with the Royal Securities Company.

Very considerable advertising material has been distributed throughout the Province by Day-Nichols Inc., a publishing house in New York. The present advertising is a book entitled "Technique of Contraception". We trust that every physician will promptly pass such advertisement to the waste basket.

Dr. R. H. McLeod of Musquodoboit, expects shortly to go to the United States in the Federal Health Service in the State of Mississippi. His place will be filled by Dr. D. R. Sutherland, Dalhousie 1925, now in Tusket, Yarmouth County. It would appear that there is another opening for a young doctor.

Dr. W. E. Fultz, Dalhousie 1925, who was interne in St. Joseph's Hospital for a year has just returned from the United States. He was an interne in the Massachussetts Eye and Ear Infirmary and then was associated with Dr. Briggs, a prominent specialist of Nashville, Tennessee. He expects during the immediate summer to supply for a number of doctors in the mining towns.

Dr. Fultz has always lived in Halifax and has been visiting at his former home.

It was a pleasure a short time ago to meet, in Kentville, Dr. Eva Mader and to learn that she had fully recovered from the Scarlet Fever which has laid her aside for over two months in connection with her health scholarship work in Toronto University. In Kentville she was visiting her sister, a patient in the Sanatorium, and in Halifax she was assisting Dr. Victor Mader in a very important event.

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Rheumatol
Hypomalt
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Cutrol
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& many others

Samples on request.

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(E. B. S.)

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Each fluid ounce contains:

Bismuth Salicyl. - -	4 grs.
Pancreatin - -	2 grs.
Diastase - -	1 gr.
Magnesium Carb. - -	60 grs.

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Hyperacidity, Flatulence, Nausea, Ulcerated Stomach, Constipation, Dyspepsia, Infantile Indigestion and other Derangements of the Digestive Function.

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VI-TONE COMPANY
HAMILTON, ONTARIO

A female Governor in the United States has released a number of prisoners. How like a woman not to let a man finish his sentence.

In a recent Tennis Tournament between Wolfville and Kentville, the *Advertiser* says: "Dr. Avery deWitt, after dropping the usual first set to Gordon Neary, exerted his old jinx on the Kentville star by winning the final two sets."

Mrs. Philip D. MacLarren has returned to the city after a visit of some weeks with her mother, Mrs. Clark, at Tatamagouche, N. S.

A wedding of very considerable interest to friends in New Glasgow and Halifax was that of Dr. Arthur E. Doull, Dalhousie 1928, now now associated with his father and Dr. Mathers in special work in Halifax. The bride was Miss Ethel McKay, daughter of Dr. John W. McKay of New Glasgow. A special feature of the wedding was the music furnished by a trio composed of Mrs. (Dr.) Benvie, Mrs. (Dr.) Bell and Mrs. Hugh McKay. During the signing of the register, Mrs. Benvie played "Because", which was followed by Mendelshonn's wedding march. A reception followed by a wedding breakfast was preliminary to their going away for a short honeymoon trip in the Province. Congratulations are extended.

A Park Avenue house which goes in for flunkeys, recently blossomed out with a new doorman. When a gentleman called and asked to see Mrs. Brown, the new attendant, true to his calling, detained him with the customary, "But is Mrs. Brown expecting you?"

The caller withered him with a glance. "My good man," he said, "Mrs. Brown was expecting me before I was born. She is my mother."

Dr. A. S. Burns of Kentville appears in District Militia Orders of June 25th, 1929 as being promoted to his Majority and attached to the K. C. H. as from April 1st, 1929. As M. D. No. 6 includes P. E. Island we note that Dr. C. C. Archibald of Charlottetown No. 26 Field Ambulance has also received his Majority.

Poor Muss Rorrissey is always getting himself into it. We overheard a conversation between Muss and Nuts Gazoobis the other day that proves it.

"Say, Mus—what's that broken out on your cheek?"

"Heck, Nuts—that's a strawberry rash."

"But strawberries ain't ripe yet."

"Huh—but I got that from a strawberry blonde."

Father—"My dear, if you insist on keeping up with fashion, you'll soon be entirely bare."

Daughter—"Well, Dad, I'd rather be a nudity than an oddity."

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Mild and incipient mental cases.

Selected habit cases will be taken on advice of physician.

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announce that they will shortly be ready to supply

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(Irradiated Ergosterol)

(Licensed under the Steenbock patent administered by the Alumni Research Foundation of the University of Wisconsin)

Viosterol, P. D. & Co., will be released for sale to the drug trade on July 25, 1929. Your druggist may not have it in stock on that date, but he can get it for you on short notice.

Viosterol, P. D. & Co., will be supplied in the form of a vegetable oil solution of irradiated ergosterol standardized to an antirachitic (vitamin D) potency of one hundred times that of high-grade cod-liver oil. It will be furnished in 5-cc. and 50-cc. packages.

Viosterol is the name adopted by the Council on Pharmacy and Chemistry of the American Medical Association to designate preparations of irradiated ergosterol.

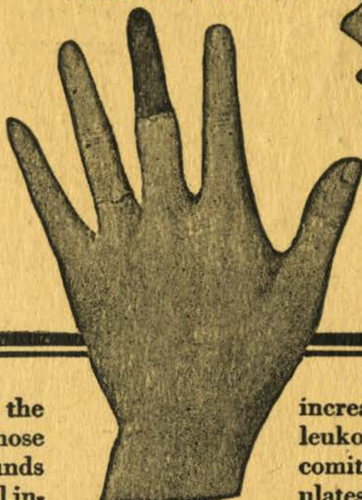
Specify "P. D. & Co."

PARKE, DAVIS & COMPANY
WALKERVILLE, ONTARIO

WINNIPEG, MAN. MONTREAL, QUE.

Positive Chemotactic Action!

Contused wound of hand, with emery ground into the wound.


Carbolic acid gangrene of finger. Result of wrapping in cloths saturated with 5 per cent carbolic acid.

Same hand after removal of the Antiphlogistine dressing.

In infections of the hand and in those accidental wounds associated with bacterial invasion of the body, the application of Antiphlogistine means *fortified resistance to infection plus rapid regeneration of damaged tissue.*

The immediate effect of an Antiphlogistine dressing is to induce an active hyperemia and relaxation of the smaller arteries, bringing into the involved tissues a greater number of leukocytes in proportion as the volume of arterial blood is increased. The advent of leukocytes and the concomitant leucocytosis stimulates the blood-forming mechanism to greater activity and hastens the new formation of fixed tissue elements upon which the entire healing process depends.

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is a scientific antiphlogistic, supporting and augmenting the defensive mechanism of the body at every stage of the inflammatory or infectious process.

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